CODE	Section IX MEDICARE ORGANIZATION DETERMINATIONS & APPEALS Standard of 95 percent relates to requirements of timeliness, accuracy and disclosure. Use Worksheet: WS AP1-AP4
AP01	**The M+CO is ultimately responsible for the appeals function. The M+CO establishes, maintains, and follows both standard and expedited appeal procedures and procedures for standard and expedited organization determinations. The M+CO informs all enrollees in writing of the standard and expedited appeal procedures and procedures for standard and expedited organization determinations.** **42CFR422.80(c)(1)(iii); ~~422.562(a)(3); 422.568(d)(3); 422.570(b)(1); 422.570(c)(2)(ii); 422.570(d); 422.572(e)(2)(ii)~~ 42 CFR 422 Subpart M** **[ ] MET [ ] NOT MET[ ] NOTE**
AP02	**The M+CO properly defines and identifies complaints that are organization determinations, i.e.,:** ● **reimbursement for emergency, urgently needed, post-stabilization care services as well as temporarily out of the area renal dialysis services;** ● **Payment for services furnished by nonaffiliated providers or suppliers that the enrollee believes are covered by the M+CO under Medicare, ~~by the M+CO contract (including optional supplemental benefits) and~~ or if not covered under Medicare should have been furnished, arranged for, or reimbursed by the M+CO, which includes pre-approved maintenance of care and post-stabilization services;** ● **Refusal to provide or pay for services ~~which the M+CO refuses to provide~~ that the enrollee believes should be furnished or arranged for by the M+CO and the enrollee has not received outside the M+CO;** ● **discontinuation of a service, if the enrollee ~~disagrees with the determination that the service is no longer~~ believes that continuation of the services is medically necessary and** ● **Failure of the M+CO to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.** **42CFR422.2; 422.100(b)~~(1)(iv)(a&b)~~; 422.566(b)** **[ ] MET [ ] NOT MET[ ] NOTE**
AP03	**The M+CO makes an organization determination to provide, authorize, deny, or discontinue a service as expeditiously as the enrollee's health condition requires, but no later than, 14 calendar days for a standard request, 72 hours ~~of~~ for an expedited request. ~~according to prompt payment provisions outlined in 42CFR422.520 (see section VIII of this guide, Claims Processing CP03), or within 60 calendar days of the request for payment of a service.~~** **42CFR422.572(a)(b); ~~422.590(d)~~; 422.568(a) and (b); ~~422.520~~** **[ ] MET [ ] NOT MET[ ] NOTE**
~~Note to~~ **AP03 (a)**	**Extension in timeframes for requests for standard and expedited organizational determinations. If the enrollee requests an extension or if the M+CO justifies a need for additional information and ~~documents~~ how the delay is in the interest of the enrollee, ~~then the case of a standard or expedited request for service,~~ the M+CO may extend the time frame by up to 14 calendar days. When the M+CO extends the timeframe, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he/she disagrees with the M+CO's decision to grant itself an extension.**

	42CFR422.572(~~a~~) (b);422.568(a)

AP04 ~~**New Element**~~	**The M+CO must demonstrate that appeal rights were sent to a member. If an M+CO denies a service or payment in whole or in part, then it must give the enrollee written notice of that determination. (Even if the M+CO fails to provide the enrollee with timely notice of an organization determination, this failure constitutes an adverse organization determination and may be appealed.) (A course of treatment which is ending or is being modified due to the patient's improvement in medical condition is appealable if the enrollee ~~disagrees that the service is no longer necessary~~ believes that continuation of the services is medically necessary or the change in course of treatment will inhibit the beneficiary from achieving maximum function.)** **42CFR422.80(c)(1)(iii); 422.568~~(c)&(e)~~ (d)&(f); 422.572(e)&(f) QISMC 2.4.1.3 (See QR20)** **[ ] MET [ ] NOT MET[ ] NOTE**
AP05	**The M+CO's decision to deny payment for claims, refusal to provide or authorize a service, or decision to discontinue a service (if the enrollee ~~disagrees that the~~ communicates to the M+CO that he/she believes that continuation of the services is ~~no longer~~ medically necessary), is an adverse organization determination. An adverse organization determination must be in writing. ~~In addition, an organization determination to discontinue inpatient services must be in writing (see AP06).~~ A written notice of adverse organization determination must include the following:** **~~(Note: Written notice is currently not required for reduction of services, unless objections are raised; e.g., fewer number of physical therapy sessions per week, lower dosage of medication, etc.)~~** • **states the specific reasons for the denial;** • **uses approved notice language in a readable and understandable form;** • **informs the enrollee of his or her right to a reconsideration, including the right to an expedited reconsideration; [Expedited reconsideration language not required on denied claims.]** • **provides parties to the reconsideration reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing;** • **specifies who may file a reconsideration;** • **includes information explaining that physicians may act on behalf of an enrollee in time-sensitive situations (service denials only);** • **explains the 30-calendar day appeal process for service denials;** • **explains the 60-calendar day appeal process for payment denials;** • **explains the 72-hour expedited appeal process for requests for service(s) where waiting for the standard time frame could jeopardize the enrollee's life or health, or ability to regain maximum function (service denials only);** • **instructs beneficiaries how to obtain help with filing an appeal;** • **describes the PRO quality complaint process;** • **describes the M+CO quality complaint process; and** • **informs members of the need for representative statement or waiver.** **~~NOTE: Denials creating no further liability to the beneficiary are exempt from the appeals process. CFR 422.562(c)(2) These include duplicate claims, denial of lab services because it was not requested by the referring physician, denials because~~**

	~~the claim was for utilization purposes or because the provider missed the filing time frames.~~ 42CFR422.568~~(c&d)~~ (d&e); CHPP/HPPA 7/22/1997 memorandum to health plans; OPL99.082 [ ] MET [ ] NOT MET[ ] NOTE

~~AP06 New Element~~	~~A written notice of a discontinuation of inpatient care (Notice of Discharge and Medicare Appeal Rights [NODMAR]) is provided to the enrollee whenever an enrollee is discharged from inpatient hospital care. The NODMAR must include: 1) reason why inpatient care is no longer needed; 2) the effective date of the enrollee's risk of financial liability for continued inpatient care; and 3) the enrollee's appeal rights.~~ ~~42CFR422.620; OPL 99.082~~ ~~[ ] MET [ ] NOT MET[ ] NOTE~~
AP07	The M+CO develops procedures to ensure that delegated providers are fully informed of organization determination and appeal procedures and are informed of their responsibility to provide a written ~~a~~ notice of adverse organization determinations to the enrollee when: 1) a service or payment is denied and 2) an enrollee objects to discontinuation of a service~~, including distinct requirements when inpatient hospital care is discontinued~~. The M+CO is responsible for monitoring and ensuring that proper organization determination and appeal procedures are being followed by delegated providers. Cross refer to ~~AM02.~~ AM10(l) 42CFR422.562(a)(3) [ ] MET [ ] NOT MET[ ] NOTE
AP08	The M+CO accepts written requests for standard reconsideration filed within 60-calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration filed after 60-calendar days). 42CFR422.582(b)&(c) [ ] MET [ ] NOT MET[ ] NOTE
AP09	A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is ~~Requests for reconsideration by the organization of~~ a denial based on lack of medical necessity, ~~are reviewed~~ the reconsidered determination must be made by a physician ~~who is appropriately credentialed with respect to the treatment involved~~ with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician. ~~and who is not the individual who made the initial determination~~. 42 CFR 422.590(g)(1)&(2), QISMC domain 2.4.3.3 [ ] MET [ ] NOT MET [ ] NOTE
AP10	If the M+CO ~~either~~ makes a fully favorable decision, ~~and~~ it issues a decision to the enrollee as expeditiously as the enrollees health condition requires, but not later than ~~within~~ 30-calendar days from the date it receives the request for a standard reconsideration or 72 hours for an expedited reconsideration for service denials, or within 60-calendar days for payment denials. ~~or,~~ If the M+CO is unable to make a fully favorable decision, the M+CO forwards the case to HCFA's independent contractor as expeditiously as the enrollees health condition requires, but not later than ~~within~~ 30-calendar days for standard

	service denials (or if it is an expedited reconsideration within 24 hours of its decision) ~~and~~ or 60-calendar days for payment denials, from date of receipt of the reconsideration request. The M+CO ~~and~~ concurrently notifies the beneficiary of ~~the~~ this action. The M+CO will make reasonable and diligent efforts to assist in gathering and forwarding information to HCFA's contractor. 42CFR422.590(a)~~(2)~~; (b)~~(2)~~; (d)(5) [ ] MET [ ] NOT MET[ ] NOTE
~~Note to~~ AP10 (a)	If the enrollee requests an extension or if the M+CO justifies a need for additional information and how the delay is in the interest of the enrollee, then in the case of a standard or expedited reconsideration request for service the M+CO may extend the time frame by up to 14 additional calendar days~~. However, the M+CO must document how the delay is in the interest of the enrollee~~ When the M+CO grants an extension, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he/she disagrees with the M+CO's decision to grant an extension. ~~42CFR422.572(a) (b); 422.568(a)~~ 42 CFR 590(a)(1) and (d)(2).

AP11	STANDARD RECONSIDERATIONS: Reversals by the M+CO. If the reconsidered determination wholly reverses the M+CO's initial adverse organization determination (i.e., holds the M+CO liable), then the M+CO authorizes, provides or pays for the service according to the following requirements: • Requests for service. If the M+CO's reconsideration decision for a service request is completely in favor of the enrollee, the M+CO must ~~effectuate, (i.e.~~ authorize or provide~~)~~ the service as expeditiously as the enrollee's health condition requires, but no later than 30-calendar days from the date it receives the reconsideration request. 42CFR422.590(a)(1) & 422.618(a)(1). • Requests for payment. If the M+CO's reconsideration decision is completely in favor of the enrollee for a claims issue, then the M+CO must effectuate the payment no later than 60-calender days from the date it receives the request. ~~42CFR422.590(a)(1) & 422.618(a) – service and~~ 422.590~~(a)(2)~~(b) and 422.618(a)(2). ~~– claims~~ ~~• If the independent reconsideration contractor (currently CHDR), or an outside entity at a higher level of appeal, reverses, wholly or in part, the M+CO's initial adverse organization determination, the M+CO must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60-calender days from the date it receives the notice reversing the organization determination. The M+CO must also inform the independent outside entity that the organization has effectuated the decision.~~ Reversals by the independent outside entity: • Requests for service. If on reconsideration, the M+CO's organization determination is reversed in whole or in part by the independent outside entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the enrollee's health condition requires (but no later than 14 calendar days from that date). The M+CO must inform the independent outside entity that the organization has effecutated the decision

42 CFR 422.618 (b)(1)

- **Requests for payment. If on reconsideration, the M+CO's organization determination is reversed in whole or in part by the independent outside entity, the M+CO must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination. The M+CO must inform the independent outside entity that the organization has effecutated the decision. 42 CFR 422.618(b)(2)**

Reversals other than by the M+CO or the independent outside entity:

- **If the independent outside entity's determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the M+CO must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60-calender days from the date it receives the notice reversing the organization determination. The M+CO must also inform the independent outside entity that the organization has effectuated the decision. 42CFR422.618 ~~(b) (1 2)~~ (c)**

EXPEDITED RECONSIDERED DETERMINATIONS:

Reversals by the M+CO.

- **If on reconsideration of an expedited request for service, the M+CO completely reverses its organization determination, the M+CO must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the date the M+CO receives the request for reconsideration or no later than upon expiration of an extension. (If the enrollee requests an extension or if the M+CO justifies a need for additional information and how the delay is in the interest of the enrollee, the M+CO may extend the timeframe by up to 14 calendar days. When the M+CO extends the timeframe, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if they disagree with the M+CO's decision to grant itself an extension.) 42 CFR 422.590(d); 422.619(a).**

Reversal by the independent outside entity.

- **If the M+CO's determination is reversed in whole or in part by the independent outside entity, the M+CO must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. The M+CO must inform the independent outside entity that the organization has effectuated the decision. 42 CFR 422.619(b)**

Reversal other than by the M+CO or the independent outside entity.

- **If the independent review entity's expedited determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 60 days from the date it receives notice reversing the determination. M+CO must**

	inform the independent outside entity that the organization has effecutated the decision. 42 CFR 422.619(c) **[ ] MET [ ] NOT MET[ ] NOTE**
MOE AP 01-11	~~Interview: Staff who receive and process enrollee complaints.~~ **Interview:** Staff who receive and process enrollee complaints. **NOTE RELATED TO AP01 - AP09:** Applies to Organization Determinations: AP01, AP02, AP03, AP03(a), AP04, AP05, AP07 Applies to Appeals: AP01, AP04, AP05, AP06, AP07, AP08, AP09, AP11 Applies to Expedited Organization Determinations: AP01, AP03, AP03(a) Applies to Expedited Appeals: AP01, AP10, AP10A **NOTE RELATED TO AP05:** ***If an enrollee requests an M+CO to provide a detailed notice of a practitioner's decision to deny a service in whole or in part, it must give the enrollee written notice of the determination. 42 CFR 422.568(d).*** Denials creating no further liability to the beneficiary are exempt from the appeals process. CFR 422.562(c)(2) These include duplicate claims, denial of lab services because it was not requested by the referring physician, denials because the claim was for utilization purposes or because the provider missed the filing time frames. In order to have a MET for AP05, the notice must include all requirements listed in the element (where not specifically excluded). ~~NOTE RELATED TO AP07 and AP12: AP07 addresses compliance with a determination of a standard reconsideration and AP12 addresses compliance with a determination of an expedited reconsideration~~. **NOTE RELATED TO AP10**: The M+CO may not issue an unfavorable reconsideration decision and must notify beneficiaries that their appeal case file is being forwarded to the HCFA contractor. The M+CO must inform enrollees of the need for a representative statement when the enrollee appoints a representative. The M+CO must inform the non-contracted physician/provider of the need for a waiver of payment statement when he or she files for payment on his or her own behalf. Language used in expedited notices should reflect model language provided in 7/22/97 memorandum from CHPP ~~and a forthcoming OPL from CBS (expected August 1999).~~ Expedited reconsideration requests can be presented orally or in writing and are filed directly with the M+CO. All of the above: M+CO's decision~~s~~ not to expedite must be processed as a standard appeal and the enrollee/representative must be notified promptly (with follow-up in writing within ~~2~~ 3 calendar days). M+CO must demonstrate, i.e., by documented files, the fact that enrollee is given an opportunity to present evidence and his or her response to this invitation. Expedited appeals may not be filed with Social Security Administration (SSA) District Offices (DO) or the Railroad Retirement Board (RRB).

For cases where the M+CO must receive medical information from a physician or provider not affiliated with the M+CO, the M+CO ~~72-hour processing time standard begins with the M+CO's receipt of the information.~~ must request the necessary information from the noncontracted provider within 24 hours of the initial request for an expedited reconsideration. Regardless of whether the M+CO must request information from the noncontracted providers, the M+CO is responsible for meeting the timeframe and notice requirements.

Determine:

- ❏ whether the M+CO's staff: 1) have procedures for reviewing adverse organization determinations; 2) are aware of and correctly distinguish issues subject to the Medicare appeal process and those subject to the Medicare grievance process; and 3) are aware of and can correctly distinguish issues subject to the standard 30-calendar day timeframe ~~Medicare appeal process~~ for service denials, ~~and~~ 60-calendar day timeframe ~~Medicare appeal process~~ for payment denials and the 72-hour timeframe for expedited appeals ~~process~~, (which includes oral requests).
- ❏ if the M+CO provides written notice to beneficiaries: ~~1) when inpatient, care is terminated, even if enrollee does not object to termination of care, 2)~~ (1) for all denials of service or payment, and ~~3)~~(2) other circumstances when the enrollee ~~objects~~ believes that continuation of services are medically necessary.
- ❏ whether the M+CO processes standard and expedited appeal cases within required time frames.
- ❏ whether the M+CO effectuates standard and expedited appeal cases within required time frames. A reopening of a reconsideration determination by the independent review entity does not relieve the M+CO of the obligation to effectuate the reconsideration determination within the required time frames.
- ❏ where the M+CO utilizes the 14-day extension, whether the reason for that extension was valid (e.g., enrollee requested it, or additional time would benefit the beneficiary), ~~and was~~ documented and written notice was provided to the enrollee informing him/her of the reasons for the delay and the right to file a grievance if he/she disagrees with the M+CO's decision to grant an extension. ~~(e.g., enrollee requested it, or additional time would benefit the beneficiary)~~ (AP03(a) and AP10(a)).
- ❏ ~~The physician must be appropriately credentialed. If the organization delegates any phase of the reconsideration process to a subcontractor, the subcontractor must have its own procedures for complying with this standard. This standard means that the reconsideration function may not be delegated to a single provider (AP09).~~

Review:

- ❏ M+CO's ~~subscriber agreement~~, evidence of coverage, member handbook, marketing material that describes appeal procedures, including expedited appeal procedures. (See corresponding marketing elements/~~Section VII~~ Section IV, & marketing material review log. Materials should have been reviewed during ongoing marketing review.)
- ❏ Denial notices/notices of non-coverage, and other outgoing correspondence for appropriate appeal language.
- ❏ Contracting providers' procedures to determine how the M+CO deals with denials of service and complaints that are organization determinations. In conjunction with this, examine the provider manual to ensure that clear, written instructions are given to providers and suppliers. If the appeal function is delegated, does the M+CO have a written procedure to monitor the appeal process?
- ❏ Telephone and complaint logs; note time frames for addressing enrollee complaints.
- ❏ Enrollee concerns to determine whether they are correctly identified and referred to the appropriate department.
- ❏ Appeal cases processed by the M+CO for accuracy and timeliness of the determination.

	❑ Cases referred to HCFA's independent contractor for timeliness of referral and timeliness of notification to enrollees of that referral~~.~~ ❑ HCFA contractor records. Prior to site visit, contact the HCFA Central Office contractor Project Officer in CBS regarding M+CO's record on reversals of reconsideration cases and request reports (if HCFA contractor reports have not already been received). A high turnover rate raises questions as to whether there are problems related to informing enrollees, availability/accessibility of services, quality assurance, etc. Coordinate with other review sections, as appropriate. ❑M+CO's effectuation of overturned decisions for accuracy and timeliness.

AP12	**The M+CO must provide an expedited review (for organization determinations or reconsideration) when any physician (either contracting or non-contracting) ~~acts on behalf of an enrollee to~~ requests an expedited review or supports the enrollee's request, if the physician indicates ~~belief~~ that applying the standard time frame could seriously jeopardize the life ~~and~~ or health of the enrollee or the enrollee's ability to regain maximum function.** **42CFR422.570(a); 422.570(c)(2)(ii); 422.584(a); (c)(2)(ii)** **[ ] MET [ ] NOT MET[ ] NOTE**
MOE AP~~10~~ 12	~~Applies to Expedited Organization Determinations: AP10~~ ~~Applies to Expedited Appeals: AP10, AP10A, AP11, AP12~~ Applies to Expedited Organization Determinations & Expedited Appeals: AP12 **NOTE:** Physicians may request ~~(and M+COs must honor/expedite such requests~~) expedited organization determinations (pre-service) and expedited reconsiderations without the need for a representative statement signed by the enrollee or the enrollee's legal representative. M+CO must expedit~~e review~~ reconsideration requests that are: 1) filed by a physician (oral or written) on behalf of enrollee ~~(needs representative statement);~~ or 2) an enrollee requested appeal when accompanied by a physician statement of support (oral or written) of the expedited reconsideration~~. [A physician request for expedited review and/or a physician's support for an enrollee request for expedited review must~~ if the physician indicates that applying the standard timeframe could seriously jeopardize the ~~that~~ life~~,~~ or health of the enrollee or the enrollee's ability to regain maximum function. ~~could be in jeopardy if the expedited process is not followed.]~~ For a request made by an enrollee, the M+CO must provide an expedited determination if it determines that applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. ~~EXAMPLES:~~ ~~• All appeals regarding discontinuation of inpatient hospital services (including rehabilitation and psychiatric care) should be appealed to the PRO if enrollee is able to file timely, i.e., by noon of the first working day after receipt of written notice of non-coverage),~~ ~~• Otherwise, for those enrollees who miss the PRO deadline, an expedited review may be requested.~~

	• ~~In most cases review requests related to termination of SNF services or physical/speech therapy (either as outpatient or an inpatient.~~
AP13 **~~New Element~~**	**The M+CO maintains written documentation in a case file of any and all oral request(s) for an expedited organization determination or reconsideration.** **42CFR422.584(c)(1); 422.570(c)(1)** **[ ] MET [ ] NOT MET [ ] NOTE**
~~AP14~~	~~The M+CO makes its reconsidered decision within, 30 calendar days for standard requests or 72 hours for expedited requests, unless an extension of 14 calendar days is requested by either the enrollee or the M+CO; if the decision is not fully favorable to the beneficiary, the M+CO sends the appeal case to HCFA's contractor within, 24 hours for expedited appeals, and within 30 calendar days for standard appeals.~~ ~~42CFR422.572(b); 422.590(a)(1);422.590(a)(2); 422.590(d)(2); 422.590(d)(5)~~ ~~[ ] MET [ ] NOT MET [ ] NOTE~~
~~AP15~~	~~The M+CO complies with the reversal of the adverse organization determination, as expeditiously as the enrollees health condition requires but no later than~~ ~~• 30 calendar days for M+CO reversal. [or within the 14 day extension period as specified in 42 CFR 422.590(a)(1).~~ ~~42CFR422.618(a); 422.618(b); 422.572 (a & d); 422.590(a)(1)~~ ~~[ ] MET [ ] NOT MET [ ] NOTE~~

AP 16 ~~**New Element**~~	**The M+CO complies with the requirement to disclose to beneficiaries upon request appropriate appeals data. The M+CO is required to collect and report information on:** • **The time period covered** • **Total number of requests for an appeal by the M+CO** • **Average number of enrollees in the organization** • **Total number of appeals per 1000 enrollees** • **Number of appeals completed during the submitted data collection period** • **Number of appeals decided fully in favor of the enrollee** • **Number of appeals NOT decided fully in favor of the enrollee** • **Number of appeal requests withdrawn by the enrollee** • **Number of appeals sent to the independent review entity for review (of the cases sent to the review entity)** **-number of cases decided by independent review entity decided fully in favor of the enrollee** **-number of cases NOT decided by independent review entity fully in favor of the enrollee** **-number of cases withdrawn by the enrollee from the independent review entity** **-number of cases awaiting decision by the independent review entity** • **The number of expedited appeal requests during the submitted data collection period** **-number of expedited appeals granted** **-number of expedited appeals NOT granted** **42CFR 422.111(c)(3); OPL 99.081; OPL 2000.114** **[ ] MET [ ] NOT MET [ ] NOTE** ~~**NOTE: THIS REQUIREMENT BECOMES EFFECTIVE IN 1/1/2000. DATA COLLECTED AND REFRESHED EVERY 6 MONTHS. THE FIRST PERIOD OF COLLECTION WILL INCLUDE DATA FROM 4/1/99-9/30/99.**~~